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One can simply cut the stitches that hold the sheath device in place and either cut the sheath in such a way as to not damage the balloon pump catheter within it or slide the sheath back out of the artery entry site. In either case, one is leaving a less obstructing device within the femoral and iliac artery. This small increase in distance between the balloon pump catheter and the native lumen of the femoral artery and iliac artery has been sufficient in our recent cases to reestablish a pulse distally in the limb and to avoid having to remove the entire balloon pump, which of course is critical in patients who are dependent upon it for a satisfactory blood pressure.

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Coronary Angioplasty and Balloon Aortic Valvuloplasty in a High Risk Group of Patients: A Promising Approach

The report of Cribier et al. (1) on balloon valvuloplasty of adult aortic stenosis was very important because their results demonstrated the feasibility of this approach in a high risk group of patients for valve replacement. Dash (2) made some important comments about that report (1) and we would like to point out that "palliation with balloon valvuloplasty does not alter the poor prognosis when associated with multivessel coronary disease" (2).

We had the opportunity to report in our first three cases with calcific aortic stenosis and balloon valvuloplasty that a 70 year old woman had an associated and successful coronary angioplasty (left circumflex artery) at the same session (3).

We have performed 18 balloon valvuloplasties for patients with calcific aortic stenosis since October 1986. One of these patients, an 84 year old woman with rest angina despite medical treatment, had clinical and echocardiographic diagnosis of calcific aortic stenosis. She was referred to cardiac catheterization and possible balloon valvuloplasty. The systolic gradient was 73 mm Hg and the aortic valve was calcific but no regurgitation was present. Coronary angiography showed 1) a 40% stenosis in the left main coronary artery; 2) a 90% segmental stenosis in the proximal portion of the left anterior descending coronary artery before the first diagonal branch (important branch) and total occlusion after it with collateral circulation; 3) a 90% segmental stenosis in the proximal portion of the left circumflex coronary artery; and 4) a 90% concentric stenosis in the proximal portion of the right coronary artery. The left ventricular ejection fraction was 0.64. At the same session, balloon valvuloplasty (15 mm balloon) was successfully performed (the residual gradient was 20 mm Hg and there was no regurgitation) and followed by successful coronary angioplasty in the proximal stenosis of the left anterior descending coronary artery and in the right coronary artery. The procedure was performed through the right brachial artery. The patient has been totally asymptomatic during a follow-up period of 3 months.

In summary, balloon aortic valvuloplasty plus coronary angioplasty is a feasible approach and should be tried when possible to obtain a more palliative treatment.

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Correction

In the August issue, an error was made in the article: Surawicz B: Prognosis of ventricular arrhythmias in relation to sudden cardiac death: therapeutic implications. J Am Coll Cardiol 1987;10:435–47. In Table 1, page 439, the third line under LVEF in column 1 should read >40% rather than <40%.